| FY07 HEALTH PLAN DESCRIPTION FORM – INO | | |
|---|---|---|
| | **INO - 30** | |
| | **In-Network Only** | **Out-of-Network Only** |
| **Important Note:** This form is not a contract. It is only a summary. The contents of this form are subject to the provisions of the Plan, which contains all terms, covenants and conditions of coverage. Your Plan may exclude coverage for certain treatments, diagnoses or services not noted below. The benefits shown in this summary may only be available if required Plan procedures are followed (e.g. Plans may require Pre-Treatment Authorization or use of specified providers or facilities). Consult the actual Summary Plan Description to determine the exact terms and conditions of coverage. Coinsurance % reflects the amount the Plan will pay. | | |
| **Part A: Type of Coverage** | | |
| **1. Type of Plan** | Preferred Provider Organization | |
| **2. Out-of-Network Care Covered?**[1] | No, except for Emergency. | |
| **3. Areas of Colorado where Plan is Available** | Plan is available nationally. | |
| **Part B: Summary of Benefits** | | |
| **4. Plan Year Deductible**<br>**a) Individual**<br>**b) Family** | <br>N/A | <br>Not Applicable |
| **5. Plan Year Out-of-Pocket maximum**[2]<br>**a) Individual**<br>**b) Family** | <br>$1,000 plus copays<br>$3,000 plus copays | <br>Not Applicable |
| **6. Lifetime Maximum** | No lifetime maximum with 2 exceptions: a) surgical treatment of morbid obesity, if Medically Necessary, is covered up to a lifetime maximum of $7,500 including complications; b) Substance Abuse 60-day inpatient and 60-visit outpatient lifetime maximum. | |
| **7. Covered Providers** | Great-West Healthcare Preferred Provider Network. Pharmacy Services provided by Express Scripts® and Vision Services provided by Avesis®. Both are by arrangement with Great-West Healthcare. | |
| **8. Medical Professional Services** | Plan pays 100%. | Not Applicable |
| **9. Office Visits** | After $30 copay for PCP and/or after $50 copay for Specialist, Plan pays 100%. | Not Applicable |
| **10. Scheduled Preventive Care**<br>**a) Children**<br>**b) Adults** | <br>After $30 copay, Plan pays 100%.<br>After $30 copay, Plan pays 100%. | <br>Not Applicable<br>Not Applicable |
| **11. Maternity**<br>**a) Prenatal care**<br>**b) Delivery & Inpatient well baby care**<br>**c) Delivery professional services** | <br>After $30 copay per visit, Plan pays 100%.<br>After $250 copay per day, up to 3 days per admission, Plan pays 100%.<br>Plan pays 100%. | <br>Not Applicable<br>Not Applicable<br>Not Applicable |
| **12. Prescription Drugs Level of coverage and restrictions on prescriptions**<br>**a) Retail Copay**<br>**- Generic**<br>**- Preferred**<br>**- Non-Preferred**<br>**b) Mail Order Copay**<br>**- Generic**<br>**- Preferred**<br>**- Non-Preferred**<br>**c) Self-admin. Injectables disp. thru Pharmacy**<br>**d) Injectables admin. in office or OP facility** | a) & b) & c) subject to $100 per member Rx deductible before copays apply.<br><br>$10<br>$25<br>$50<br>(30-day supply)<br><br>$20<br>$50<br>$100<br>(90-day supply)<br>**Plan pays 70%. Member share not to exceed $250 per 34-day supply or $500 per 90-day supply.**<br>**Plan pays 70%.** | Not Applicable<br><br>Not Applicable<br><br>Not Applicable<br><br>Not Applicable<br><br>Not Applicable |

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| The Prescription Drug Program has been designed to encourage the use of generic medications. If a generic drug is available, but the preferred drug is dispensed (whether by your request or upon a physician specifying "Dispense As Written"), you are required to pay the applicable preferred copayment PLUS the difference in cost between the generic and preferred drug. The Food and Drug Administration (FDA) requires generic drugs to have the same quality, strength, purity and stability as preferred drugs. | | |
| **13. Inpatient Hospital** | After $250 copay per day, up to 3 days per admission, Plan pays 100%. | Not Applicable |
| **14. Outpatient / Ambulatory Surgery** | After $150 copay per surgery or invasive diagnostic tests, Plan pays 100%. | Not Applicable |
| **15. Other services** | | |
| **a) Laboratory** | If not part of an office visit or inpatient, Plan pays 80%. | Not Applicable |
| **b) X-ray** | If not part of an office visit or inpatient, Plan pays 80%. | Not Applicable |
| **c) MRI / PET / CAT scans** | After $75 copay, Plan pays 80% per visit | Not Applicable |
| **b) & c) subject to Pre-Treatment Authorization** | | |
| **16. Emergency Care**[3] | After $100 copay (waived if admitted), Plan pays 100%. | Not Applicable |
| **17. Ambulance** | | |
| **a) Ground** | Member pays 20%, maximum benefit $1,000 | |
| **b) Air** | Member pays 20%, maximum benefit $10,000 | |
| **18. Urgent Care**[3] | After $50 copay, Plan pays 100%. | Not Applicable |
| **19. Biologically Based Mental Health**[4] **Care** | Covered same as any other illness. | Not Applicable |
| **20. Other Mental Health Care** | Maximum 45 full/90 partial days inpatient services and 30 visits for outpatient services per Plan Year. Maximum number of days and visits combined with Substance Abuse. | |
| **a) Inpatient care** | Plan pays 50%. | Not Applicable |
| **b) Outpatient care** | Plan pays 50%. | Not Applicable |
| **21. Substance Abuse** | Maximum 45 full/90 partial days for inpatient and 30 visits for outpatient per Plan Year. Number of days and visits are combined with other Mental Health. Lifetime maximum 60 full days for inpatient and 60 visits for outpatient. Other Mental Health is not subject to the 60-day or 60-visit lifetime limit, but inpatient days and outpatient visits for such services do apply to and reduce the 60-day or 60-visit lifetime limit for Substance Abuse. | |
| **a) Inpatient Rehab.** | Plan pays 50%. | Not Applicable |
| **b) Outpatient** | Plan pays 50%. | Not Applicable |
| **22. Physical, Occupational & Speech Therapy** | | |
| **a) Inpatient** | Included in Hospital | Not Applicable |
| **b) Outpatient** | After $30 copay, Plan pays 100%. Maximum 20 visits per Plan Year for each therapy. | Not Applicable |
| **23. Durable Medical Equipment** | | |
| **a) Inpatient** | Included in Hospital | Not Applicable |
| **b) Outpatient including supp.** | Plan pays 80% up to $3,000 per Plan Year. (Prosthetic devices are not subject to $3,000 max, but expenses for such devices are applied to and reduce the $3,000 max.) | Not Applicable |
| **24. Medical Supplies** | Plan pays 80%. | Not Applicable |
| **25. Oxygen** | | |
| **a) Inpatient** | Included in Hospital | Not Applicable |
| **b) Outpatient** | Member pays 20%. | Not Applicable |
| **26. Transplants** | After $250 copay per day, up to 3 days per admission, Plan pays 100%. | Not Applicable |

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| **27. Home Health Care** ***subject to Pre-Treatment Authorization*** | After $30 copay for 60 visits per Plan Year, Plan pays 100%. | Not Applicable |
| **28. Hospice**<br>**a) Inpatient**<br>**b) Outpatient** | <br>Member pays 20% for 30 days per Plan Year.<br>Member pays 20% for 91 days per Plan Year. | <br>Not Applicable.<br>Not Applicable. |
| **29. Skilled Nursing Facility Care** | Member pays 20% for 30 days per Plan Year. | Not Applicable |
| **30. Dental Care** | Not covered | Not covered |
| **31. Vision Care** | After $30 copay, Plan pays 100%. One exam every Plan Year. No benefit for hardware, but a discount is available through Avesis® network. | Not Applicable |
| **32. Chiropractic Care and Acupuncture** | After $30 copay, Plan pays 100%. Maximum benefit of $750 per Plan Year per benefit. | Not Applicable |
| **33. Significant Additional Covered Services**<br>**a) Hearing Aids**<br>**b) Infertility** | <br>Plan pays 100% up to $500 every 3 years.<br>Member pays 20% up to $2,500 per Plan Year. | <br>Not Applicable |
| **Part C: Limitations and Exclusions** | | |
| **34. Period during which Pre-Existing Conditions are not Covered.** | Not applicable. Plan does not impose limitation periods for pre-existing conditions. | |
| **35. What Treatments & Conditions are excluded Under this Policy?** | See Summary Plan Description for list of exclusions. | |
| **Part D: Using the Plan** | | |
| **36. Does the enrollee have to obtain a referral for specialty care in most or all cases?** | No | No |
| **37. Is Pre-Treatment Authorization required for surgical procedures and hospital care (except in an emergency)?** | Yes. See Summary Plan Description for list of procedures. | Yes. See Summary Plan Description for list of procedures. |
| **38. If the provider charges more for a covered service than the Plan normally pays, does the enrollee have to pay the difference?** | Not if the provider participates with Great-West Healthcare. | |
| **39. What is the main customer service number?** | 1-888-ST8-OFCO (1-888-788-6326) | |
| **40. Whom do I write/call if I have a complaint or want to file a grievance?** | Call the Great-West Customer Service Department at (1-888-788-6326) | |
| **41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?** | Submit Appeals form to:<br>**Great-West Healthcare**<br>Attention: Appeals/Grievances<br>8525 E. Orchard Road, 4T3<br>Greenwood Village, Colorado 80111 | |

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| **42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.** | Policy Number: 179528<br>Self-funded large group. | |
| **43. Does the Plan have a binding arbitration clause?** | No | |
| **Part E: Cost** | | |
| **44. What is the cost of this Plan?**<br>**a) Employee Only**<br>**b) Employee + Child(ren)**<br>**c) Employee + Spouse**<br>**d) Family** | Rates are available on the Benefits website<br>www.colorado.gov/dpa/dhr/benefits. | |

[1]Network refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your Plan may require you to use in order for you to get any coverage at all under the Plan, or that the Plan may encourage you to use because it pays more of your bill if you use their network providers (i.e. go in-network) than if you don't (i.e. go out-of-network).

[2]Out-of-pocket maximum. The maximum amount you will have to pay for allowable covered expenses under a health Plan, which may or may not include the deductible or copay, depending on the contract for that Plan.

[3]Emergency Care means the sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. Urgent care means situations that are not life threatening but require prompt medical attention to prevent serious deterioration in a member's health.

[4]Biologically based Mental Health means autism, schizophrenia, schizo-affective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder and panic disorder.